FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
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March 20, 2007

Casey Meza
St Marys Hospital
P.O. Box 137
Cottonwood, ID 83522

Re: Provider #131321

Dear Mr. Meza:

This is to advise you of the findings of the Medicare swing bed survey of St Marys Hospital which was done on March 1, 2007.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form HCFA-2567, listing Medicare Deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for **all** individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the deficient system to insure compliance is achieved and maintained. Included how the monitoring will be done and at what frequency.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 2, 2007**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131321	A. BUILDING _____ B. WING _____	03/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARYS HOSPITAL	701 LEWISTON ST, PO BOX 137 COTTONWOOD, ID 83522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were: Gary Guiles, R.N., H.F.S., Team Leader Rae Jean McPhillips, R.N., H.F.S. Patrick Hendrickson, R.N., H.F.S. Abbreviations include: CAH = Critical Access Hospital J-P = Jackson - Pratt MVA = Moter Vehicle Accident RN = Registered Nurse OR = Operating Room	C 000	RECEIVED APR - 9 2007 FACILITY STANDARDS	
C 298	485.635(d)(4) NURSING SERVICES - CARE PLANS A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on interview and review of current and closed records, it was determined the CAH failed to ensure care plans were fully developed for 4 of 4 acute care patients (#'s 6, 7, 8 and 18), whose records were reviewed for care planning. This created the potential for unmet needs. The findings include: * Patient #6, a 46 year old female, was admitted to the acute care unit following a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and appendectomy on 12/26/06. She was discharged home on 12/29/06. The care plan, dated 12/26/06, documented the "Problem" was "potential for clot formation." The "Expected	C 298	C-298 – The care planning process and requirements for documenting a nursing care plan will be reviewed with the nursing staff by the end of May 07. Standardized nursing care plans will be developed and implemented by the end of May 07. A care planning quality indicator will be added to the Quality Scorecard and monitored on an ongoing basis until results show that care plans are being consistently completed and include all problems, potential problems, interventions, effectiveness of interventions, timelines, both short-term and long-term goals, pt./family teaching plan and socio-psychological needs of pt. and a plan to meet those needs.	5/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dris Dawley for Casey Mesa — TITLE: Director of Pt Care Services — (X6) DATE: 4/5/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 298	Continued From page 1 Outcome/Goal" was "zero clots - history of MVA 3 days ago" and the "Action/Intervention" was "bruising at seat belt area/SEQ/increased ambulation after OR." The care plan did not address how frequently staff were to implement the interventions or provide direction on providing cares. The care plan did not identify other potential problems related to the surgery or MVA, such as the surgical wound or possible respiratory complications. Additionally, the care plan did not document that staff assessed the patient to ascertain the effectiveness of interventions. * Patient #7, a 53 year old female, was admitted to acute care with a diagnosis of possible ileus and exploratory laparoscopy on 10/30/06. She was discharged home on 11/01/06. The care plan, dated 10/30/06, documented the patient's "Problem" was "abdominal pain." The "Expected Outcome/Goal" established was "pain will be controlled throughout hospitalization" and the "Action/Intervention" was "pain meds, positioning." The care plan did not guide staff on what "positioning" was to be used or how often the interventions were to be implemented. The patient's care plan did not contain documentation that staff assessed the patient to ascertain the effectiveness of the interventions. Additionally, the care plan did not address other potential problems that may occur post-operatively. * Patient #18, a 16 year old female, was admitted to the acute care unit on 2/27/06 for a infected cesarean section surgical incision. The care plan documented one "Problem" as "drainage", the "Expected Outcome/Goal" was "zero", and the "Action/Intervention" was "J-P drain." The care plan failed to guide staff on how frequently the	C 298		

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C 298	Continued From page 2 J-P drain was to be monitored or emptied. The care plan did not address other potential problems with the drainage such as dressing changes. The patient's care plan did not contain documentation that staff assessed the patient to ascertain the effectiveness of the intervention. Additionally, the care plan did not identify other potential problems the patient may have had such as pain, possible depression, or any issues related to postpartum. On 3/1/07 at 10:15 AM the Director of Patient Care Services acknowledged the findings of the record review.	C 298		
C 395	485.645(d)(6) COMPREHENSIVE CARE PLANS (483.20(k)(1)) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This STANDARD is not met as evidenced by: Based on the review of closed records, it was determined the CAH failed to ensure comprehensive care plans were developed for 2	C 395	C-395 – A standardized comprehensive care plan will be developed and implemented that can be individualized for each Resident that will include measurable objectives and timetables to meet each resident's individual medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment by the end of May 07. A care planning quality indicator will be added to the Quality Scorecard and monitored on an ongoing basis until results show that care plans are being consistently completed for each Resident.	5/07

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C 395	Continued From page 3 of 4 Swing-bed patients (#'s 11 and 17), whose records were reviewed. This created the potential for unmet needs. The findings include: * Patient #11, an 81 year old male, was admitted to Swing-bed status on 1/4/07 and discharged on 1/7/07. The admitting diagnoses to Swing-bed were hypotension and lightheadedness. The care plan, dated 1/4/07, identified the "Problem" was "risk for social isolation." There was no "Expected Outcome/Goal" established for the patient. The "Action/Intervention" was to offer "one on one" daily and to offer activities. Further review of the record documented the "one to one" visits occurred on 1/4/07 and 1/5/07. No visits were documented to have occurred on 1/6/07 or 1/7/07. There was no documentation on the care plan as to what activities staff were to offer or the frequency. Additionally, the issues or potential problems related to the patient's diagnoses were not addressed on the care plan. * Patient #17, an 88 year old male, was admitted to Swing-bed status 12/17/06 and discharged back to a long term care facility on 12/20/06. The admitting diagnoses included subclavian deep vein thrombosis and decreased responsiveness. The care plan, dated 12/17/07, identified the "Problem" as "risk for social isolation" the "Expected Outcome/Goal" as increased "social interaction" and the "Action/Intervention" as "media, visit". There was no documentation on the care plan as to what the term "media" meant or how frequently staff were to visit the patient. Additionally, the issues or potential problems related to the patient's diagnoses were not addressed on the care plan.	C 395		
C 396	485.645(d)(6) COMPREHENSIVE CARE PLANS (483.20(k)(2))	C 396		

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C 396	Continued From page 4 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This STANDARD is not met as evidenced by: Based on the review of closed records, it was determined the CAH failed to ensure that a comprehensive care plan was developed for 1 of 4 Swing-bed patients (#16), whose record was reviewed. This created the potential for unmet needs. The findings include: * Patient #16, a 68 year old female, was admitted to Swing-bed status with a diagnosis of pneumonia, on 12/29/06 and discharged on 12/30/06. The plan care, dated 12/26/06, was from her acute care hospitalization on 12/26/06. No documentation was found to indicate a comprehensive care plan had been developed when the patient was transferred to Swing-bed status.	C 396	C-396 – A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment by an interdisciplinary team on all Swing Bed patients. A standardized comprehensive care plan will be developed and implemented by the end of May 07. A care planning quality indicator will be added to the quality scorecard and monitored on an ongoing basis until results show that care plans are being consistently completed for each Resident.	5/07
C 400	485.645(d)(9) NUTRITION (483.25(i)(1)) Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	C 400		

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C 400	Continued From page 5 demonstrates that this is not possible. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure 4 of 4 Swing-bed patients (#'s 11, 12, 16, and 17), whose records were reviewed on 2/28/07 were assessed for nutritional needs. This created the potential that Swing-bed patients would not maintain acceptable parameters of nutritional status. 1. 4 Swing-bed patients' records lacked nutritional assessments. The findings include: * Patient #11, an 81 year old male, was admitted to Swing-bed status on 1/4/07. His diagnoses included hypotension, lightheadedness and urinary retention. The patient was discharged to his home on 1/7/07. No documentation was found to indicate the patient had received a nutritional assessment. * Patient #12, a 69 year old female, was admitted to Swing-bed status on 1/16/07. Her diagnoses included deep vein thrombosis. The patient was discharged to her home on 1/17/07. No documentation was found to indicate a nutritional assessment had been completed. * Patient #16, a 68 year old female, was admitted to Swing-bed status on 12/29/06. Her diagnoses included pneumonia. The patient was discharged to her home on 12/30/06. The patient's Plan of Care documented that a referral was made to the dietary department on 12/26/06 and that a visit from dietary staff occurred on 12/29/06. However, the record did not contain a copy of the nutritional assessment.	C 400	C-400 – The Dietary Supervisor has been advised and agreed to conduct nutritional assessments on all swing bed patients on admission beginning immediately. Swing-bed patients will now be automatically referred for a nutritional assessment via the new Meditech order entry module which goes live on April 18, 07. A quality measure has been in place and is included on the quality scorecard. This will continue to be monitored and corrective actions will be taken as needed.	4/5/07

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C 400	Continued From page 6 * Patient #17, an 88 year old male, was admitted to Swing-bed status on 12/17/06. His diagnoses included deep vein thrombosis, weakness, and decreased responsiveness. The patient was discharged back to a long term care facility on 12/20/06. No documentation was found to indicated the patient had received a nutritional assessment. 2. The Dietary Supervisor was interviewed on 3/1/07 at 9:05 AM. He stated that he had not been conducting nutritional assessments for patients admitted to Swing-bed status. 3. The patients' records were reviewed with the Director of Patient Care Services on 3/1/07 at 10:15 AM. She confirmed the lack of nutritional assessments. Additionally, she stated it was the policy of the CAH that all patients admitted to Swing-bed status were to be referred to and be assessed by dietary services and that this policy had not been followed.	C 400		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were: Gary Guiles, R.N., H.F.S., Team Leader Rae Jean McPhillips, R.N., H.F.S. Patrick Hendrickson, R.N., H.F.S.	B 000		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to C298.	BB175	BB-175 – The care planning process and requirements for documenting a nursing care plan will be reviewed with the nursing staff by the end of May 07. Standardized nursing care plans will be developed and implemented by the end of May 07. A care planning quality indicator will be added to the Quality Scorecard and monitored on an ongoing basis until results show that care plans are being consistently completed and include all problems, potential problems, interventions, effectiveness of interventions, timelines, both short-term and long-term goals, pt./family teaching plan and socio-psychological needs of pt. and a plan to meet those needs.	5/07
BB228	16.03.14.330.08 Security 08. Security. The pharmacist is responsible for	BB228		

RECEIVED
APR - 9 2007
FACILITY STANDARDS

Bureau of Facility Standards

Iris Hawley for Casey Maza — TITLE Director of Pt Care Services — (X6) DATE 4/5/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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BB228	Continued From page 1 the drug storage security elements of the designated areas. Access to the pharmacy shall be gained only by him and by individuals designated by him. All prescribed medications shall be under lock and schedule II drugs shall be double-locked. (10-14-88) This Rule is not met as evidenced by: Based on record review, staff interview and observation it was determined the pharmacist failed to ensure that all prescribed medications were secure and under lock. The findings include: 1. During a tour of the hospital on 2/28/07 at 9:15 a.m., with the Director of Patient Care Services, "DPCS" the medication delivery cart was observed in the medical unit hall unlocked. The DPCS acknowledged the medication delivery cart was unlocked and stated that staff were to have the cart locked when unattended. On 2/28/07 at 4:50 p.m., the medication delivery cart was again observed unlocked in the medical hall . The charge nurse acknowledged the medication delivery cart was unlocked and stated she had just walked away from the cart for a second and forgot to lock the medication delivery cart. During a tour of the Birthing Room on 3/1/07 at 10:30 a.m., with the pharmacist, a medication cabinet was observed in the Birthing Room unlocked and had no locking mechanism. The medications were easily accessible to patients and visitors. The pharmacist stated she did not know the medication cabinet in the Birthing Room needed to be locked. During a tour of the Emergency Room on 3/1/07	BB228	BB-228 – Administration has reviewed pharmacy responsibilities for drug storage security elements with the pharmacist. All prescribed medications have been locked and scheduled II drugs are double locked. Maintenance and Nursing will develop a new locking mechanism for the medication cabinet in the birthing room. This will be implemented by the end of April 07. Quality monitor will be implemented to insure compliance.	4/07

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BB228	Continued From page 2 at 10:50 a.m., with the pharmacist, a cabinet containing medications was observed to be unlocked. The medications were easily accessible to patients and visitors. The pharmacist acknowledged the cabinet containing medications in the Emergency Room needed to be locked and the locking mechanism was not engaged. On 3/1/07 at 4:40 p.m., the Emergency Room medication cabinet was again to be observed unlocked. The charge nurse acknowledged the Emergency Room medication cabinet was unlocked and stated she did not know the cabinet containing the medication's in the Emergency Room needed to be locked. 2. Review of the Pharmacy's Polices on 3/1/07 revealed the following: Policy # 301-105. The medication delivery cart will be parked next to the medication room and locked at all times. Policy #707-017. The hospital will make reasonable effort to provide security for the drug stock. The hospital and pharmacist failed to ensure that prescribed medications in the medication delivery cart, Delivery Room and Emergency Room were under lock and secure.	BB228		